Show Some Emotion: Completing the Cycle of Affective Communication

(1999)

Karen J. Maroda

Editors' Introduction

With the shift from a one-person to a two-person psychology that has defined the relational turn in psychoanalysis has come a heightened attention to the personal involvement of patient and analyst and of the affective link between them. Karen Maroda has courageously called for emotional honesty and affective self-disclosure in the analytic encounter. While Maroda's work is profoundly personal and creative, however, more than others, she has also insisted that theorists of psychoanalytic technique articulate the principles that guide their clinical interventions so that these procedures can be taught and studied systematically. She began to outline her own systematization of psychoanalytic technique in her 1991 book, *The Power of Countertransference* (reprinted 2004 by The Analytic Press) and continued her exploration in *Seduction, Surrender, and Transformation* (1999, The Analytic Press), a sample from which follows.

What are the actual clinical implications of a relational approach for psychoanalytic technique and practice? In the chapter-sample that follows, Karen Maroda calls on psychotherapists to "show some

emotion." Maroda proposes a thoroughly interactive model of psychoanalytic practice in which the patient learns through the medium of affective communication with the analyst. Maroda grounds her technical recommendations in a clinical theory of affect. Given that most patients have problems with affect management, completing cycles of affective communication between therapist and patient becomes vitally important in the therapeutic process.

Maroda's writing is consistently passionate, challenging, and provocative. Where psychoanalysis used to call for abstinence, neutrality, and anonymity, Maroda pushes for emotional honesty and personal availability. In the introduction to *Seduction, Surrender, and Transformation,* Maroda writes that "relational analysis requires both parties to examine how and why they are in conflict—what led up to this event, how each person experiences it, how each person's history sets the stage for the current conflict, and finally, how they must reveal their emotional responses to each other and resolve the conflicts as best they can" (p. 4).

While promoting radical mutuality and a thoroughly interactive clinical methodology, Maroda never avoids or neglects facing the role of power and authority within the analytic dyad. She remains carefully attentive to the asymmetries of power and to the need to develop psychoanalytic principles of technique that protect the integrity of the analytic process.

Show Some Emotion: Completing the Cycle of Affective Communication*

▽ ▽ ▽ ▽ ▽

Mutual surrender is a sine qua non for therapeutic action, that is, change. But what actually takes place in this moment of surrender that allows for change or transformation? In order to understand and facilitate a therapeutic surrender, we need to understand better the nature of affects and the role of emotion in individual growth and development,

* An earlier version of this chapter appears in Karen J. Maroda, *Seduction, Surrender, and Transformation: Emotional Engagement in the Analytic Process.* © 1999 The Analytic Press, Inc.

as well as in the therapeutic process. What follows is both a review of the relevant literature on emotions, and an application of this information to the therapeutic process. It appears that many, if not most, of our patients suffer from impairments in affective experience and regulation, and that there is evidence that we need to express our own emotions to facilitate our patients' affective development. Building on Stern's (1985) notions of *intereffectivity* and *affective attunement*, I propose that the analyst's affective responses are critical for completing the cycle of affective communication. This chapter concludes with an in-depth discussion of the clinical implications of the uses of emotion in analytic treatment.

Psychoanalysis and Affective Theory

First, what is the role of affect in classical analysis? Shapiro and Emde (1991) make the point that Freud and his followers "did not develop a coherent model accounting for affectivity in clinical theory and even less so in metapsychology" (p. iii). Blum (1991) adds that Freud focused rather narrowly on the notion of affective abreaction, or the notion of reliving a traumatic incident and catharting the disturbing emotions. (See Spezzano, 1993, for a comprehensive review of the literature on affect in psychoanalysis.) Little was known during Freud's lifetime about affective development, let alone the neurological foundation and locations for affective experience. I make this point not in the interest of criticizing classical theory or practice, but rather to emphasize the obvious: as research in human development and neuropsychology provide new information that has important implications for the therapeutic process, we have the opportunity to modify our ideas and interventions accordingly. And the topic of affect now affords us just such an opportunity.

The cumulative research over the past 30 years tells us much about affect development and the importance of affective communication. The essence of this chapter is that the *mutually affective moment* constitutes what is therapeutic between analytic therapist and patient. And that the therapist plays a critical role in helping patients compensate for early deficits in the ability to know, feel, name, express, and manage both the basic, innate affects (e.g., fear and anger) and the more differentiated and cognitively mediated affects (e.g., shame and love). Thus, just as the mother played this role in early childhood, the therapist facilitates the cycle of affective communication within the therapeutic relationship.

If we look at the child research for clues as to what our adult patients need, there is a plethora of information. Schore (1994) notes that as early as 60 years ago,

> the Russian psychologist Vygotsky, studying the basic mechanism underlying the internalization of higher psychological functions, posited the general developmental principle that all psychological processes appear first at an interpersonal and only later at an intrapersonal level . . . all higher functions emerge as a result of social interaction [p. 358].

This is an amazing statement that, if true, validates not only the therapeutic enterprise, but also the contemporary emphasis on the interpersonal aspects of treatment. Vygotsky's theory supports the notion that intrapsychic change across a broad array occurs as a result of interpersonal exchanges, lending credence to the concept of a more active, expressive therapist. But is Vygotsky's theory supported by modern research? To a great degree, it is. Stern (1985), in reporting his research results, says:

> One conclusion is that the infant somehow makes a match between the feeling state as experience within and as seen "on" or "in" another, a match that we can call *interaffectivity*.
>
> Interaffectivity may be the first, most pervasive, and most immediately important form of sharing subjective experiences. Demos (1980, 1982a), Thoman and Acebo (1983), Tronick (1979), and others, as well as psychoanalysts, propose that early in life affects are both the primary *medium* and the primary *subject* of communication [pp. 132–133].

The primary importance of affect continues as the infant evolves, and at around nine months, according to Stern, mothers naturally change the nature of their affective responses, moving from mere imitation of the infants' affect to responding with their own affective expressions. Stern says that "what is being matched is not the other person's behavior per se, but rather some aspect of the behavior that reflects the person's feeling state" (p. 142). He refers to this affective matching between mother and infant as "*affective attunement*."

Although the literature on adults does not address the issue of affective attunement per se, the longstanding recognition of the therapeutic benefits of high-level empathy can be understood as a similar mechanism for promoting affective development in the therapeutic relationship. The analytic theory most compatible with a notion of the need for a life-long affective attunement with others would be Kohut's (1984) ideas regarding the never-ending need for mature selelf objects who, by definition, provide needed empathy and affective responding.

Stern (1985), Stolorow, Brandchaft, and Atwood (1987) and Stolorow and Atwood (1992) emphasize that infants and children are heavily dependent on affective responses from their caretakers. Without affective responses they lack internal organization and the ability to express and contain their own affective experiences. Stolorow and Atwood (1992) refer to Krystal, stating that

> Krystal (1988) has suggested that a critical dimension of affective development is the evolution of affects from their early form, in which they are experienced as bodily sensations, into subjective states that can gradually be verbally articulated. . . .
>
> [A]ffects may fail to evolve from bodily states to feelings because, in the absence of validating responsiveness, they are never able to become symbolically articulated. Hence the person remains literally alexithymic [pp. 186, 187].

Alexithymia, of course, is the inability to express, differentiate, and name emotions (with the exception of occasional angry outbursts) and usually results from childhood trauma. While most patients do not present with alexithymia, most patients are lacking in affect development in some significant way. Brown (1993) notes that developmental failures in affect may "manifest themselves in one or more areas: expression, experience, tolerance, verbalization, recognition, orientation, transformation, and consciousness of affective processes, respectively" (p. 43). So we are left with the knowledge that the "capacity for affective expression may be innate, but the capacity for affect experience unfolds in the course of development" (p. 6). As the child develops, he or she builds an increasing repertoire of emotions and learns that affects are a primary mode of communication, that they act as "signals for another person" (Krystal, 1988, p. 17). Children's abilities to accurately label and express their feelings are highly dependent on how often and to what degree their caretakers express their own feelings (Brody and Harrison, 1987). Krystal (1988) also tells us that a critical dimension of affective development is the "evolution of affects from their early form, in which they are experienced as bodily sensations, into subjective states that can gradually be verbally articulated" (p. 42). (He notes that alexithymic patients remain stuck at the level of experiencing affect only, or primarily, as physical sensations or symptoms.) The most significant aspect of affect that *does not change with development* is that "nothing becomes an emotion until it travels outside of the brain to the musculature and microcirculation of the face, there to be assessed and interpreted as an affective response" (Nathanson, 1996, p. 385). (Tomkins, 1962, of course, did the pioneering research on innate affect and its expression on the face.) So when we think we know what a patient is feeling by the look on his or her face we are probably right. Just as the patient knows what we are feeling in the same way.

Much of the controversy regarding therapist self-disclosure has been based not just on the issue of "contamination" but also on the relative superficiality assumed in the verbal exchanges between therapist and patient. Where is the unconscious in all of this? Are we simply to assume that both analyst and patient actually know what each is feeling most of the time? The answer to that is no, of course not. An accurate reading of affect depends on both parties' trusting their visceral responses to, and sufficient ability to read, a variety of facial expressions. And these expressions will occur, even if one is unaware of them. My patient, Susan, who is alexithymic and almost always denies being angry, very often registers the facial expression documented by Tomkins (1962) as rage. And I find myself feeling uneasy and somewhat defended when she walks into her session wearing this facial expression, no matter what she says to me about what she is feeling. Her face and my gut reaction match each other and tell more truth than what she can always consciously know.

Another important aspect of the expression of emotion is that it is social (Parkinson, 1996) and, as such, often appears just as the patient enters the office. The expression has been saved for me, or occurs in response to me, for a specific purpose, whether or not the patient is aware of this purpose. Parkinson cites a study by Kraut and Johnston (1979), who observed bowlers and noted that they had one set of responses when they turned to face the other bowlers, the latter responses being much more animated and expressive. When they were facing the pins, there was no point in registering any facial expressions, because there was no one to receive them. Parkinson cites this as evidence that emotions are social and serve as a form of communication. He says,

Teletherapy role

> Many emotions have relational rather than personal meanings (e.g., deRivera, 1984) and the expression of these meanings in an emotional interaction serves specific interpersonal functions depending on the nature of the emotion . . . emotion is social through and through. Its fundamental basis in many cases is as a form of communication [p. 680].

Therefore, therapists and patients alike constantly register emotional reactions to each other, helping to inform each other of their true feelings, regardless of their conscious experience.

To summarize, infants and children learn to express their emotions freely, and ultimately, through their mothers' responses, learn how to name, differentiate, and manage them. Initially the mother typically only mirrors the child's rather basic expression, but as the child expands his or her repertoire the mother responds, not just with mirroring, but mixes in her own personal emotional response. As Thompson (1988) says, "Emotion is initially regulated by others, but over the course of early development it becomes increasingly self-regulated as a result of neuropsychological development" (p. 371). Since these experiences are universal, doesn't it seem likely that the therapist helping an adult with affective regulation problems would need to follow the same basic principles for facilitating affective regulation that are used in childhood? Both verbal and nonverbal interventions need to be appropriate for the adult patient, yet it is hard to imagine that the process for learning affect management would differ substantially regardless of the age of the patient. If we further consider that the route to intrapersonal development is relational, or interpersonal, then the affective attunement between analyst and patient becomes a critical variable in the therapeutic action.

Written on the Body

Although I concur with Stolorow, Atwood, and Krystal regarding the importance of reciprocal mutual influence for the regulation and integration of affective experience, I *disagree* with the implied conclusion that children evolve into adults who rely primarily on symbolic articulation of affect—words. Certainly, if all goes well, the acquisition of language facilitates the regulation of affect, in that it gives the individual the opportunity to label, discuss, understand, and mediate affective states. A basic analytic tenet says that we use our intellect to help organize and regulate our affective experiences. Verbal expressions also allow some form of affective communication in instances when strong displays of emotion might be considered socially inappropriate and would therefore be punished.

While acknowledging the inherent importance of developing the ability to label and discuss emotions rather than only experiencing them as bodily states, I disagree with the assumption that continued development negates the critical aspect of *physically experiencing emotions* to complete an affective communication. We all know that we experience feeling viscerally and that this is true throughout our lifetime. Our minds do not cue us that we are feeling something strongly; our bodies do. Our minds inquire as to the origin and meaning of that feeling, and help us to manage those feelings. But without the bodily sensation, there is no inquiry. (After all, even in adulthood the face remains the primary signaler of an affective event, rather than verbal expressions.)

Fast (1992) tried to recapture the importance of the body, as well as the mind, in her paper on mind-body and the relational perspective. She says that while Freud's notions of bodily involvement in emotional states

were erroneous, he was correct in assuming a mind-body relationship. She notes that even though Freud understood well that infants cannot separate thought from bodily action, he chose to emphasize the later period when mental consideration preceded motoric action.

Fast credits Piaget for noting a mind-body period of development. But, like Freud, he proposed that normal development progresses to the point where the capacity for thought is free of the body. The implication is that emotion is registered intellectually, *in the mind*, rather than physically, *in the body*, if development occurs normally. Therefore, even though it is undoubtedly true that the capacity for verbalizing and cognitively mediating emotion evolves developmentally, the body never ceases to be a critical part of the emotion-signaling system, which Kelly (1996) describes as "critical for immediate, first-line survival" (p. 61).

Grotstein (1997), lamenting the separation of mind and body in analytic thinking, says they are

> always inseparable but that they *seem* to lend themselves to the Cartesian artifice of disconnection so that we can conceive of one or another for the sake of discrimination. Put another way, I believe that the *mindbody* constitutes a single, holistic entity, one that we can think about and believe that we can imaginatively experience as being separate but that is mockingly *nonseparate* all the while [p. 205].

Psychoanalysis, as it recognizes the importance of affect in human development, subsequently faces the task of re-integration of mind and body. What we know to be true is that patients who have been traumatized, and also the general population of personality disorders, demonstrate developmental failures in experiencing and managing affect. And these people represent a large percentage of those currently seeking treatment. Of course, it is no news to most clinicians that many of our patients suffer from the inability to experience and regulate their emotions. Much of the countertransference literature focuses on the affective onslaught one faces when treating many cases of narcissistic and border-line personality disorders. We have known for a long time that affect regulation is a problem that these patients bring to treatment and that presents a significant challenge to us as therapists. But I would have to add that I do not think we have been terribly successful in developing adequate theories and techniques for dealing with these patients. And the idea of using our bodily sensations as signals remains foreign.

To what extent do both our patients and ourselves use our bodies to register, and even communicate, deep emotions? I doubt that anyone could honestly say that he experiences a deep emotion without some observable accompanying physical sensation. And perhaps, in our desire to elevate the mind above the body, we have underestimated the role of the body in communication.

If we conceive of projective identification as primarily a body-to-body communication, then the simple containment of that affect by the analyst is insufficient on two grounds: one, letting the patient know that the communication has been received, and two, helping the patient to translate his emotional state into verbal representations—something that is essential to communication in the adult world. Understanding that the ability to verbalize affective states is a developmental achievement only partially acquired by many of our patients, we can naturally look more closely at body language, physical sensations, and projective identifications to help us understand and treat our patients. I think our resistance to "going first" when it comes to verbalized affective expressions often deprives our patients of the affective responding they need to further their own development.

We seem obsessed with the notion of "containment" of the patient's affect, which has limited value in terms of helping the patient with affect regulation. And I often wonder *who* or *what* we are really interested in *containing*. Discussions of therapist expression of affect at professional meetings often reflect a myriad of fears over what will happen if the analyst is overtly emotional. Terms like "out of control" and "potential for abuse" often drown out any serious discussion of how to use emotion constructively in the analytic setting.

Is Affect Inhibition Overvalued?

It seems that we have few problems diagnosing patients who suffer from the inability to contain and mediate their affective responses. These are the patients who often make our lives miserable as we attempt to cope with their emotional outbursts and impulsive behaviors. Unquestionably, treating people who are consistently out of control is challenging and stressful. But what about the patients who are *overcontrolled*? Do we worry less about them, and become complacent because they can provide an often much-needed respite from our patients who overwhelm us with their affective regulation problems?

In recent years Krystal (1988) and McDougall (1982) have raised our awareness of the patients who are alexithymic. Rather than presenting hysterically, these patients are very much in control and take pride in their cool, calm, collected manner, which society often rewards. Krystal says,

> What is deceptive to those unfamiliar with this disturbance is that these patients, who often function very successfully in their work, appear

> "superadjusted" to reality and lead one to expect excellent intellectual function. However, getting past the superficial impression of superb functioning, one uncovers a sterility and monotony of ideas and severe impoverishment of the imagination [p. 247].

Susan, the aforementioned patient whom I have chosen to use throughout this volume, certainly qualifies as alexithymic, arriving for her first session immaculately dressed, polite, pleasant, and appearing to function at a high level. When I asked her if she had ever been in treatment before, she related a history of four previous therapists, although none for any length of time, all of whom deemed her to be quite sane. One simply dismissed her as not needing therapy. And another took her as a lover, in part because she perceived Susan as wealthier, more successful, and more in control than she. The therapist's wish to be taken care of by Susan emerged soon after they began their affair. What made me aware that there was more to Susan than met the eye was her history and her current lack of emotional distress or insight regarding her life situation. You may recall that she came for therapy because she was unable to look for work and did not understand why. She was also socially isolated, lonely, and had no insight into her past failed relationships, including the affair with her last therapist. She showed no emotion when I questioned her about her past and expressed what I considered to be an unnatural lack of anger or regret over her therapist's abuse of her. She said that she dumped the therapist and had felt in control of the whole affair, so there was no reason to be upset. These attitudes told me that Susan had some very serious emotional problems, no matter how cool she seemed. In the sessions that followed over the next few months, Susan showed the same lack of emotion when she described her rather traumatic childhood, which included daily verbal and physical abuse by her parents. She described her mother as being completely emotionless, a "blank screen" who would not tolerate any show of emotion by her children, deeming it a "sign of weakness." Susan never remembered her dreams and literally did not know what I was talking about when I asked her about her fantasies.

Patients like Susan often spend years in psychoanalysis, dully repeating the details of their lives, but rarely getting any better. However, unless they regress (in which case all hell breaks loose), these patients do not demand our attention. Krystal (1988) notes that they come on time, pay their fees, and are generally responsible and undemanding. Yet their problems are just as serious as the patients who constantly demand that we notice them. Averill (1994) points out that

> the person who cannot express emotion in an open and effective manner when appropriate is as much out of control as is the person who habitually "lets it all hang out." Control implies the ability to respond in the way one wants, whether that entails the inhibition or expression of a response [p. 267].

I would add that it is not only what the person wants that is important, but also what is emotionally honest and what is optimally desirable at the moment. But I agree with Averill that helping our inhibited, cooperative, and well-behaved patients to be more emotional should be as important as helping our over-emotional patients to contain themselves. The fact that society will reward the former but not the latter should not cloud our clinical assessment of the patient's capacity for healthy affect regulation.

Emotion and Cognition

First of all, all learning is facilitated through emotion. Contrary to what many people believe, cognitive processing is effected significantly by emotion. People are far more likely to remember something that elicited an emotional reaction (Bower, 1994). Panskepp (1994) cites research that demonstrates the critical role of emotion in all types of cognitive functions

> [T]he easiest way to light up higher mental processes—of thought, strategies, and conniving—is to activate basic emotional systems (Gray, 1990). When these basic systems have been aroused, then cognitive activity flows spontaneously [p. 313].

This information stands in stark contrast to the belief that emotions hinder or prevent clear thinking, reasoning, and problem solving. Certainly excessive emotion impairs reality testing and, good judgment, but the optimal condition is ongoing, manageable emotional stimulation, not the absence of strong feeling. Emotion plays an important role not only in the quality of cognition, but also in the type. Clore (1994) says that

> findings suggest that emotion influences cognitive processing, perhaps in very fundamental ways. Positive affect appears to encourage unconstrained, heuristic processing, sometimes with creative results, while sad affect seems to foster a focus on more controlled, systematic processing [p. 110].

So the nature of our feelings also determines the nature of our thoughts and vice versa. (The cognitive behaviorists have at least half of thi

right.) The essential role of emotion in effective information processing highlights not only the patient's need for ongoing, regulated affect, but also the therapist's. As I stated earlier in this volume, the analytic therapist who places too much emphasis on thoughts and interpretations, and avoids having strong feelings, cannot only fail to stimulate affective expression and management in her patients, but also will fail to *think optimally about the patient's condition and needs.* Just as mind and body cannot be separated, neither can feelings and thoughts.

Furthermore, the established relationship between emotion and cognition provides evidence that a good treatment needs to be an ongoing emotional event. If we accept that people change only when they can feel deeply and freely, when these feelings are responded to affectively by another person, and that both negative and positive affects provide opportunities for different types of cognitive processing, the responsibility for the analytic therapist to be emotionally involved, available, and expressive becomes greater.

What Is Emotional Memory?

Orange (1995) brought the concept of emotional memory to the forefront of analytic thinking. She says it "includes any form or part of experience that largely bypasses cognitive processes and carries significant residues from the intersubjective worlds of the past. Emotional memory has an unmediated quality that makes it feel compelling" (p. 113). She talks about how emotions can actually have a life of their own, which when I read it, seemed like a foreign idea to me. Didn't I just say that thoughts and feelings operate in concert? How then, can there be a strictly emotional memory? And what does emotional memory have to do with current functioning and the treatment situation?

For one thing, the concept of emotional memory is somewhat vague and unproven in the broad application that Orange provides. She built on the ideas of Emde, whom Clyman (1991) quotes regarding the idea of a recurrent pattern of affective experience. Clyman says that "Emde (1983) has suggested that there is a prerepresentational 'affective core of the self' which guarantees our sense of continuity across development in spite of the many ways we change" (p. 378). In other words, we have fairly stable ways of emotionally experiencing life that is not significantly altered by new experience. In this sense, a core affective pattern would be part of a necessary homeostasis, a notion supported by Schore (1994).

> Early object relational experiences thus directly influence the emergence of a frontolimbic system in the right hemisphere that can adaptively autoregulate both positive and negative affect in response to changes in the socioemotional environment. . . . The core of the self lies in patterns of affect regulation that integrates a sense of self across state transitions, thereby allowing for a continuity of inner experience [p. 33].

So there is clinical and experimental evidence that stable affective patterns, as well as specific affective reactions, exist and are called forth by stimuli that somehow mimic the original event. And Freud, once again, turns out to have known quite a bit. He hypothesized that we tended to recreate the same emotional scenarios over and over again, although he did not know at the time that affect-laden experiences actually have their own independent storehouse in the brain, ready to be recalled at an instant. I would add to this that the re-experiencing of past, intense affect is always a visceral event that is part of what makes it so real in the present, even if it entails some cognitive distortion so that it can be ordered up. For example, in the case of Susan, when she lies down on the couch and talks to me about how abusive her parents were, she begins to have these feelings all over again. The fact that her parents would throw her down on the floor and stand over her, sometimes slapping her, only increases the intensity of her equating the analytic process (lying on the couch, with me slightly away and above her in my chair) with her most negative early childhood experiences. Susan honestly feels at those moments that I am abusing her just as her parents did. She is swept away by her emotional memories and the visceral reenactment she experiences. In her mind, I must hold and comfort her to prove that I am different from her parents and not taking sadistic delight in her agony.

LeDoux (1994) tells us that it is important to distinguish between emotional memory and memory of emotion:

> The latter is a declarative, conscious memory of an emotional experience. It is stored as a fact about an emotional episode.
>
> Emotional memory (mediated by the amygdala) and memory of emotion (mediated by the hippocampus) can be reactivated in parallel on later occasions. . . . In summary, emotional and declarative memory about emotion are mediated by different brain systems. These systems operate simultaneously and parallel during experiences. As a result, we can have conscious insight into our emotions and emotional memories . . . without emotions, one would have to learn the positive and negative stimulus value of situations through strictly cognitive means [p. 312].

So our emotional memory reminds us of the importance, or lack of importance, danger or safety, of everything in our environment. Emotional memory allows for homeostasis, but it is also a keystone of the phenomenon of "learning from one's experience." As LeDoux says, our emotional

memory tells us immediately what to do, saving us the trouble of thinking through every new situation. On the less adaptive side, it may also instruct us to avoid some person, place or thing that reminds us of something unpleasant from the past that may, in reality, offer something positive that our emotional memory blinds us to.

Once again, Freud has been vindicated, in the sense that he posited transference as an established pattern of relating and emotional responding that is cued by something in the present, but oftentimes calls up both an affective state and thoughts that may have more to do with past experience than present ones. And even though Freud intuitively understood the importance of reliving these affective states, he incorrectly concluded that the patient could *cathart* and achieve new insights and patterns of relating. Not being privy to the mechanisms for early affective expression and regulation, he could not know that the analyst's emotional participation was critical to the patient's success in recognizing, expressing, and integrating affective states. He had half the equation, perhaps because the whole equation places such great personal demands on the analyst. (If eye contact was too stressful for Freud, how could he conceive of a day marked by one emotional exchange after another?) The type of emotional availability I am discussing requires so much energy and attention from the analyst, as well as self-awareness, that it severely limits the number of patients that anyone could see in a given day. Thus, practicing this way is not only potentially personally threatening, but also places significant limits on the analyst's personal income.

Affect, Alexithymia, and Trauma

The uses of emotion are particularly important when treating patients who have suffered early trauma. Krystal (1988, 1997) has alerted us to the needs of the patients he describes as alexithymic—those who cannot recognize, or label or express emotions other than occasional outbursts of rage. He says these patients typically have been traumatized in childhood, causing them to develop into adulthood without the essential tools for expressing and containing emotions. Although the burgeoning literature on incest and other "survivors" seems to place great value on recalling past abuses, it seems that the more essential hurdle facing an individual who suffered early trauma is the identification, expression, and management of affect in the present.

If we integrate what we know about individuals who have been traumatized with Krystal's portrait of the alexithymic patient, we are left with the person who is hypervigilant, overattending to the slightest detail of the analyst's behavior or deportment, yet unaware of his or her own moods and feelings. These patients cannot answer when asked how they are feeling. As a result, they often defensively change the topic to some observation of the analyst, or they respond with what they know, usually a physical feeling or symptom. The patient may say he or she feels a weight on the chest, a stomach tied up in knots, or a current worry about having cancer, AIDS, or some other potentially fatal condition. Stuck at the level of physical processing of emotion, rather than integrating physical sensation with cognitive awareness and a language for feelings, the alexithymic patient stays away from the topic of his or her own emotions. Earlier I quoted Krystal's observation that alexithymic patients often present as "super-adjusted," preferring to remain cool and calm at all times, and often believing that any show of emotion is a sign of weakness that will be seized as an opportunity to destroy the patient.

Thus Krystal's alexithymic patient and McDougall's psychosomatic patient, as well as the myriad numbers of patients identified as having experienced early trauma, seem to have a great deal in common and be drawn from the same general pool. They somatize rather than cathart, are hypervigilant, and are lacking in basic trust. They often use projective identification as a way of communicating with their therapists, essentially letting the therapist know, "This is what I am feeling." They trust their intuition and their bodies more than their feelings, which are often just a blur of "feeling upset," and often need their analysts to self-disclose or make physical contact with them as a way of facilitating both trust and emotional communication. (See the final section of this chapter for more discussion of the clinical implications.)

Gender Differences

Finally, how are men and women different in their experience and expression of affect? Social stereotypes proclaim women as the emotional gender and men as the stoics, yet the literature on alexithymic patients refers primarily to women. If women who have been traumatized at an early age have little access to their emotions, then we have a rather large group of women who clearly defy the sexual stereotype. Yet Brody (1993) says that there is increasing evidence to support the idea that women express their emotions more intensely, both verbally and nonverbally (facial expressions), than men do. Another interesting finding reported by Brody is that "males are more intensely emotionally expressive through actions and behaviors than are females" (pp. 113–114). In other words, if a man feels strongly about something, he wants to act on that feeling in some way, while women are more content restricting themselves to verbal expressions of emotion. As I read this I couldn't

help but wonder if this helps to explain why the analytic literature (overwhelmingly dominated by male authors) historically reflects fears of analysts being out of control and acting out if they attempt to self-disclose their countertransference feelings. Could it be that these fears of acting out reflect a gender difference in emotional expression, since women typically violate the boundaries less often than men do, and do not seem to be as concerned about self-disclosure as a slippery slope?

Of course, this does not mean that we should simply dismiss the male analyst's concern about acting out. It might be fair to say that women are more likely to be comfortable with expressing their emotional responses to patients, and less likely to commit boundary violations—yet this would certainly be less likely among female therapists who had their own history of trauma and/or alexithymia. It could be equally as fair to say that male analysts (knowing their own predilection for acting on their feelings) need to be more cautious and monitor their own inclinations more carefully to preserve the boundaries. Yet the many male therapists who know they are comfortable with verbal expressions of their feelings certainly would not need to concern themselves as much with the gender difference findings.

Clinical Implications

Whether or not the gender differences in expressing emotion account for the reluctance of analysts to be more emotionally expressive, there is no doubt that therapists' expression of emotion has been a very controversial topic in recent years. Even the intersubjective theorists such as Stolorow and Atwood (1992) remain convinced of the need for abstinence on the analyst's part, in spite of their recognition of the role of "reciprocal mutual influence" (p. 18) in any intersubjective field. While these authors criticize Mitchell and others for failing to acknowledge the influence of the analyst on the process, their case material reads much like any other, with their theoretical stand being used to enlighten the analyst's interpretations rather than create a field of mutual, yet asymmetrical, affective communication. Stolorow and Atwood seem to believe that empathy alone will provide the interventions needed for the emergence of repressed affective states. But my question remains, how do you relate empathically to an *unexpressed* emotion?

Basch (1991), with reference to a narcissistic patient he was treating, makes the point that more active interventions are needed to help the patient recognize and express split-off affect, although he is not explicit in his recommendations.

> The analyst's affective abstinence that serves us so well with the psychoneurotic patient would only have played into the defense of a patient like Mr. W., a patient with a narcissistic character disorder. Since disavowal interferes with affective recognition and maturation in the area of the patient's pathology, it is pointless to play the waiting game and trust that, sooner or later, the patient will transfer what needs to be analyzed [p. 301].

In a similar vein, Krystal (1988) points to the limitations of conventional technique:

> [C]onsideration of the energizing aspects of emotions provides both a rationale for and a recognition of the need to reintegrate and self-regulatory activities as part of the psychotherapeutic work. At the same time it alerts us to the fact that classical (perhaps more accurately, "conventional") psychoanalytic technique may he missing a vital aspect of the patient's and therapist's function. Rather than taking an idealistic view of the purity of technique, we might better direct that idealism to pursuing the goal of the patient's greater self-integration [p. 125].

Thus both Basch and Krystal have noted that many of the people we treat will simply not make very much progress in the area of affective recognition and expression without direct affective interventions by the therapist. Although I discuss the specifics of self-disclosure in the following chapter, there is no question that affective interventions certainly require therapists' disclosure of felt emotion. I previously (Maroda, 1991, 1995b) outlined guidelines for therapist disclosure that allow for both emotional responses elicited by the patient's question of "How are you feeling toward me right now?" and for revelation of affect experienced as the result of projective identification. The above authors' discussion of the patient's split-off affect lends itself to further discussion of how the therapist facilitates the patient's experience of his or her own disavowed feelings. McDougall (1978), in discussing the way some patients attempt to influence their analysts, says that

> Rather than seeking to communicate moods, ideas, and free associations, the patient seems to aim at making the analyst *feel* something or stimulating him to *do* something; this "something" is incapable of being named and the patient himself is totally unaware of this aim [p. 179].

From my own experience, I would say that McDougall's "something" is usually the experience and expression of the patient's split-off affect. Unable to bear their own feelings, many patients seek to have their analysts feel and express these feelings for them, so they can find them

acceptable and learn to do this for themselves. For the therapist to deny the patient this essential experience, which we can liken to the mother's early affective responding to the infant, is to deprive the patient of an essential step in his or her affective development. Interpretations given when affect is needed amounts to anti-communication, resulting in the patient getting worse.

That is why so many patients accuse their therapists of being unresponsive no matter how concerned those therapists might genuinely be, or how hard they try. Often anything short of an affective response does not count, or register, at all for the patient. He will behave as if no response was given by the therapist, or will accuse the therapist of deliberately withholding the sought-after response. Things become understandably complicated, as McDougall says, when the patient, asked what he wants, often says he does not know, due to his having repressed the affect he is seeking to find through his analyst.

Just as our early emotional development depended on receiving affective responses from others, so does our continued development. Most certainly for those who are seeking what amounts to a remedial emotional education when they come for treatment, the affective responses of the therapist are critical for completing the cycle of affective communication.

When I read case histories I am often dismayed to discover how often therapists describe getting control of themselves after being strongly stimulated by a patient, carefully making sure that they do not express emotion when responding. If the patient is stimulating anger, for example, the therapist will wait for the wave of anger to pass, and then as cooly and calmly as possible say, "I think you would like me to feel as angry as you do." Implicit in such a response is, "But don't think for a minute that I'm going to. You can spend your entire session trying to provoke me, but I will never give you the satisfaction of seeing me angry."

When I read things like this, I always think to myself, "Why not?" Why not show the patient exactly how angry you are? What is the point of withholding emotion and thwarting the patient in his quest for affective communication? As I have stated previously (1995) he will only have to up the ante next time, until he finally gets an emotional response or gives up in despair and subsequent depressed withdrawal.

Traditionally, analytic clinicians have believed that any personal responses would only detract form the patient's experience. This made some sense if you believed that analysis was primarily an intrapsychic event. But it makes much less sense if you believe that analytic treatment is not only both intrapsychic and interpersonal, but that (as stated earlier in this chapter) the order of developmental progression dictates that the interpersonal necessarily occurs first, with the intrapsychic following.

If the patient repeatedly stimulates a strong emotion or visceral response in the analyst, then it is probably time for an affective response. So long as the therapist is reasonably in control and behaves responsibly, the show of emotion should not be damaging to the patient. (In the next chapter I address questions regarding the analyst's pathology at work, potentially coloring his affective experience of the patient.)

In reviewing the literature on affect I found an interesting chapter on affect and intimacy (Kelly, 1996) that focused chiefly on couples' intimate relationships. In this context Kelly discusses the negative outcome that results when individuals do not respond honestly with feeling to each other. Yet when I read it I was struck by how much it equally applied to the therapeutic dyad.

> All close relationships require proximity that causes us to step on each other's toes. If, for whatever reason, one does not say "ouch" and communicate the distress experienced as a result of the other's actions, a complex dilemma is created. The need to disguise the distress causes the inmost self to be hidden from the other. The distress, if unrelieved, eventually triggers anger and resentment that must also be hidden. This causes further withdrawal and hiding of the inmost self. The other, perhaps not even aware of the offense, experiences feeling of rejection triggered by the withdrawal, without information adequate to allow reestablishment of the intimate bond. Now hurt, this other may also resort to withdrawal, thus setting in motion a recursive loop of rejection and hurt [pp. 87–88].

Looking at the research on affect necessitates the question: In thwarting our patients in their quest for an emotional response from us, have we unknowingly been withholding that which could be most therapeutic? We might be tempted to rationalize our lack of overt emotional expression, on the old grounds that we will detract from the patient's experience, but this fails to address the change process. I have claimed that the patient often will be unable to ever name his own affective experience if the therapist does not feel and name it first. Likewise, Schore (1994) says that

> The psychotherapist's establishment of a dyadic affective "growth promoting environment" influences the ontogeny of homeostatic self-regulatory systems (Greenspan, 1981). Towards this end, both positive and negative classes of affect need to be transacted and regulated in the therapist-patient relationship [p. 463].

In other words, affect research suggests that emotional exchanges between therapist and patient are critical to the patient's growth and development. He states further that

> affect regulatory dialogs mediated by a psychotherapist may induce literal structural change in the form of new patterns of growth of cortical-limbic circuitries, especially in the right hemisphere which contains representation of self-and-object images [p. 469].

It stands to reason that if emotional exchanges, or lack of, created the affective patterns that a person creates over and over again, that only new emotional exchanges could facilitate the altering of old affective patterns. Changes in thoughts affect cognitive patterns in the brain, and new emotional exchanges create new emotional memories and affective patterns in the brain.

If we remember that emotion is the most basic form of communication, and is essentially relational, then perhaps we can rid ourselves of the notion that the therapist's expression of felt emotion is somehow inappropriate or damaging. Krystal (1988) has suggested that therapists' difficulty in treating alexithymic patients may be due to the frequency with which they suffer from the problem themselves. Obviously only returning to treatment could address the problems of the alexithymic therapist.

From my experience there are more therapists who have painfully sat on their emotions, erroneously believing that they were doing the right thing. For these therapists, the prospect of using their emotional responses constructively for the patient's development is a potentially rewarding and mutually healthy experience. Understanding that the withholding of felt emotion can be just as harmful as any affective expression, given its covert nature, perhaps we can explore the therapeutic nature of affect, freeing both our patients and ourselves.

References

Averill, J. (1994), The patient's experience of the analyst's subjectivity. *Psychoanal. Quart.*, 1:29–51.

Basch, M. (1991), The significance of a theory of affect. *J. Amer. Psychoanal. Assn.*, 39(Suppl.):291–304.

Blum, H. (1991), Affect theory and the theory of technique. *J. Amer. Psychoanal. Assn.*, 39 (Suppl.).

Bower, G. (1994), Some relations between emotions and memory. In: *The Nature of Emotion: Fundamental Questions*, ed. P. Eckman & R. Davison. New York: Oxford University Press, pp. 303–305.

Brody, L. (1993), On understanding gender differences in the expression of emoti on. In: *Human Feelings: Explorations in Affect Development and Meaning*. ed. S. Ablon, D. Brown, E. Khantzian & J. Mack. Hillsdale, NJ: The Analytic Press, pp. 87–121.

___ & Harrison, R. (1987), Developmental changes in children's abilities to match and label emotionally laden situations. *Motiv. & Emotion*, 2:347–365.

Brown, D. (1993), Affective development, psychopathology, and adaptation. In: *Human Feelings: Explorations in Affect Development and Meaning*, ed. S. Ablon, D. Brown, E. Khantzian & J. Mack. Hillsdale, NJ: The Analytic press, pp. 5–66.

Clore, G. (1994), Why emotions are felt. In: *The Nature of Emotion: Fundamental Questions*, ed. P. Eckman & R. Davison. New York: Oxford University Press, pp. 103–111.

Clyman, R. (1991), The procedural organization of emotions. *J. Amer. Psychoanal. Assn.*, 39(Suppl.):349–382.

Fast, I., (1992), The embodied mind: Toward a relational perspective. *Psychoanal. Dial.* 2:389–409.

Grotstein, J. (1997), "Mens sana in corpore sano": The mind and body as an "odd couple" and as an oddly coupled unity. *Psychoanal. Inq.*, 17:204–222.

Kelly, V. (1996), Affect and the redefinition of intimacy. In: *Knowing Feeling: Affect, Script and Psychotherapy*, ed. D. Nathanson. New York: Norton, pp. 379–408.

Kohut, H. (1984), *How Does Analysis Cure?* ed. A. Goldberg with P. Stepansky. Chicago: University of Chicago Press.

Kraut, R. & Johnston, R. (1979, Social and emotional messages of smiling: An ethological approach. *J. Personality & Soc. Psychol.*, 37:1539–1153.

Krystal, H. (1988), *Integration and Self-Healing: Affect, Trauma, Alexithymia*. Hillsdale, NJ: The Analytic Press.

___ (1997), Desomatization and the consequences of infantile psychic trauma. *Psychoanal. Inq.*, 17:126–150.

LeDoux, J. (1994), Memory versus emotional memory in the brain. In: *The Nature of Emotion: Fundamental Questions*, ed. P. Eckman & R. Davison. New York: Oxford University Press, pp. 311–312.

Maroda, K. (1991), *The Power of Countertransference: Innovations in Analytic Technique*. Hillsdale, NJ: The Analytic Press, 2004.

___ (1995), Projective identification and countertransference interventions: Since feeling is first. *Psychoanal. Rev.*, 82:229–247.

___ (2002), No place to hide: Affectivity, the unconscious, and development of relational techniques. *Contemp. Psychoanal.*, 38:101–120.

McDougall, J. (1978), *Plea for a Measure of Abnormality*. New York: International Universities Press.

Nathanson, D. (1996), Some closing thoughts on affect, scripts, and psychotherapy. In: *Knowing Feeling: Affect, Script and Psychotherapy*, ed. D. Nathanson. New York: Norton, pp. 379–408.

Orange, D. (1995), *Emotional Understanding*. New York: Guilford.

Panskepp, J. (1994), Subjectivity may have evolved in the brain as a simple value-coding process that promotes the learning of new behaviors. In: *The Nature of Emotion: Fundamental Questions*, ed. P. Eckman & R. Davison. New York: Oxford University Press, pp. 313–315.

In other words, affect research suggests that emotional exchanges between therapist and patient are critical to the patient's growth and development. He states further that

> affect regulatory dialogs mediated by a psychotherapist may induce literal structural change in the form of new patterns of growth of cortical-limbic circuitries, especially in the right hemisphere which contains representation of self-and-object images [p. 469].

It stands to reason that if emotional exchanges, or lack of, created the affective patterns that a person creates over and over again, that only new emotional exchanges could facilitate the altering of old affective patterns. Changes in thoughts affect cognitive patterns in the brain, and new emotional exchanges create new emotional memories and affective patterns in the brain.

If we remember that emotion is the most basic form of communication, and is essentially relational, then perhaps we can rid ourselves of the notion that the therapist's expression of felt emotion is somehow inappropriate or damaging. Krystal (1988) has suggested that therapists' difficulty in treating alexithymic patients may be due to the frequency with which they suffer from the problem themselves. Obviously only returning to treatment could address the problems of the alexithymic therapist.

From my experience there are more therapists who have painfully sat on their emotions, erroneously believing that they were doing the right thing. For these therapists, the prospect of using their emotional responses constructively for the patient's development is a potentially rewarding and mutually healthy experience. Understanding that the withholding of felt emotion can be just as harmful as any affective expression, given its covert nature, perhaps we can explore the therapeutic nature of affect, freeing both our patients and ourselves.

References

Averill, J. (1994), The patient's experience of the analyst's subjectivity. *Psychoanal. Quart.*, 1:29–51.

Basch, M. (1991), The significance of a theory of affect. *J. Amer. Psychoanal. Assn.*, 39(Suppl.):291–304.

Blum, H. (1991), Affect theory and the theory of technique. *J. Amer. Psychoanal. Assn.*, 39 (Suppl.).

Bower, G. (1994), Some relations between emotions and memory. In: *The Nature of Emotion: Fundamental Questions*, ed. P. Eckman & R. Davison. New York: Oxford University Press, pp. 303–305.

Brody, L. (1993), On understanding gender differences in the expression of emotion. In: *Human Feelings: Explorations in Affect Development and Meaning*, ed. S. Ablon, D. Brown, E. Khantzian & J. Mack. Hillsdale, NJ: The Analytic Press, pp. 87–121.

___ & Harrison, R. (1987), Developmental changes in children's abilities to match and label emotionally laden situations. *Motiv. & Emotion*, 2:347–365.

Brown, D. (1993), Affective development, psychopathology, and adaptation. In: *Human Feelings: Explorations in Affect Development and Meaning*, ed. S. Ablon, D. Brown, E. Khantzian & J. Mack. Hillsdale, NJ: The Analytic press, pp. 5–66.

Clore, G. (1994), Why emotions are felt. In: *The Nature of Emotion: Fundamental Questions*, ed. P. Eckman & R. Davison. New York: Oxford University Press, pp. 103–111.

Clyman, R. (1991), The procedural organization of emotions. *J. Amer. Psychoanal. Assn.*, 39(Suppl.):349–382.

Fast, I., (1992), The embodied mind: Toward a relational perspective. *Psychoanal. Dial.* 2:389–409.

Grotstein, J. (1997), "Mens sana in corpore sano": The mind and body as an "odd couple" and as an oddly coupled unity. *Psychoanal. Inq.*, 17:204–222.

Kelly, V. (1996), Affect and the redefinition of intimacy. In: *Knowing Feeling: Affect, Script and Psychotherapy*, ed. D. Nathanson. New York: Norton, pp. 379–408.

Kohut, H. (1984), *How Does Analysis Cure?* ed. A. Goldberg with P. Stepansky. Chicago: University of Chicago Press.

Kraut, R. & Johnston, R. (1979, Social and emotional messages of smiling: An ethological approach. *J. Personality & Soc. Psychol.*, 37:1539–1153.

Krystal, H. (1988), *Integration and Self-Healing: Affect, Trauma, Alexithymia*. Hillsdale, NJ: The Analytic Press.

___ (1997), Desomatization and the consequences of infantile psychic trauma. *Psychoanal. Inq.*, 17:126–150.

LeDoux, J. (1994), Memory versus emotional memory in the brain. In: *The Nature of Emotion: Fundamental Questions*, ed. P. Eckman & R. Davison. New York: Oxford University Press, pp. 311–312.

Maroda, K. (1991), *The Power of Countertransference: Innovations in Analytic Technique*. Hillsdale, NJ: The Analytic Press, 2004.

___ (1995), Projective identification and countertransference interventions: Since feeling is first. *Psychoanal. Rev.*, 82:229–247.

___ (2002), No place to hide: Affectivity, the unconscious, and development of relational techniques. *Contemp. Psychoanal.*, 38:101–120.

McDougall, J. (1978), *Plea for a Measure of Abnormality*. New York: International Universities Press.

Nathanson, D. (1996), Some closing thoughts on affect, scripts, and psychotherapy. In: *Knowing Feeling: Affect, Script and Psychotherapy*, ed. D. Nathanson. New York: Norton, pp. 379–408.

Orange, D. (1995), *Emotional Understanding*. New York: Guilford.

Panskepp, J. (1994), Subjectivity may have evolved in the brain as a simple value-coding process that promotes the learning of new behaviors. In: *The Nature of Emotion: Fundamental Questions*, ed. P. Eckman & R. Davison. New York: Oxford University Press, pp. 313–315.

Relational Psychoanalysis

Volume II

Innovation and Expansion

edited by
Lewis Aron
Adrienne Harris

THE ANALYTIC PRESS
2005 Hillsdale, NJ London